NON-PRIVILEGED PROVIDER
PERSONAL AND PROFESSIONAL INFORMATION SHEET

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. Chapter 55 and Section 8067 and 8013 and EO 9397.
PURPOSE: To evaluate providers' formal education, training, clinical experience, and evidence of physical, moral, and ethical capacities as they relate to the credentials function and recommendations as to the practitioners' competence to treat certain conditions and perform certain medical procedures and to determine clinical support staff providers' competence.
ROUTINE USE: Information may be released to government boards or agencies, or professional societies or organizations if needed to license or monitor health care providers' professional standards. Information may also be released to civilian medical institutions or organizations where the practitioner is applying for staff privileges during or after separation from the service or applying for employment with regards to clinical support staff providers.
DISCLOSURE IS VOLUNTARY: However, failure to provide information may result in limitation or termination of clinical privileges.

Complete all items and sections. List all dates as day-month-year. Use "NA" if not applicable. "YES" answers require full explanation in the comments section or an attached sheet of paper (indicate by number and section on the attached paper those items being commented upon.)

1. GENERAL
   Name: null

   Grade: _____ Designator: _____ SSN: _____ Rank: _____

   Maiden/Alias (Last, First, MI): _____

   Date of Birth: _____ Branch of Service: _____ Corps: _____

   Citizenship: _____ Reporting Date: _____ Rotation Date: _____
   Specialties:

   1. _____

   2. _____

   3. _____

   Local Work Address: _____
   Phone
   Work: (____) _____ Local: (____) _____ Email: _____

   Permanent Home Address: _____
   Phone
   Home: (____) _____ Cell: (____) _____ Email: _____

2. PROFESSIONAL EDUCATION AND TRAINING (List most recent first):

   a. Basic Qualifying Degree (e.g. AN, Diploma, BSN, MSN, etc.)
   Institution (Name and Location) Degree From To

   _____ _____ _____ _____

   b. Special Education (include professional course of two weeks duration or greater, LMET, or other relevant programs that pertain to practice.
   Institution (Name and Location) Specialty Type From To

   1. _____ _____

   2. _____ _____

   3. _____ _____

RE: null

c. Special Education **- continued**

Institution (Name and Location)	Specialty	Type	From	To
4.				
5.				

3. QUALIFYING AND/OR SPECIALTY CERTIFICATIONS

Certification or Recertification	Issued	Expires
1.		
2.		
3.		

4. LICENSURE OR CERTIFICATION BY STATE OR FEDERAL AGENCY (include Drug Enforcement Agency certification) – include all those either voluntarily or involuntarily withdrawn

a. State License/Certification/Registration Information

License#	State	Status	Expires
1.			
2.			
3.			
4.			

b. National Certification/Registration Information

Certification#	State	Status	Expires
1.			
2.			
3.			
4.			

c. Drug Enforcement Agency (DEA) Numbers

DEA#	State	Status	Expires
1.			
2.			

5. RELATIVE WORK EXPERIENCE

Facility	Position Title	From	To
1.			
2.			
3.			
4.			

RE: null

6. MEMBERSHIP IN PROFESSIONAL ORGANIZATIONS

	Organization/Office	Full Address	From	To
1.				
2.				
3.				
4.				

7. CONTINUING EDUCATION (CME's) for the past 2 years (use for initial appointment only).

a. Academic

	Course/Subject	Credit-Hours	Started	Ended
1.				
2.				
3.				
4.				

b. Medical Readiness Training (indicate certified [C] or trained [T])

Training	C or T	Expires	Instructor (Y or N)	Training	C or T	Expires	Instructor (Y or N)
BLS :				C-4 :			
ACLS :				NALS :			
ATLS :				PALS :			
CTTC:				NBC:			

8. PERSONAL AWARDS AND LETTERS OF RECOGNITION (list chronologically, most recent first).

	Award/Recognition
1.	
2.	
3.	
4.	

9. PUBLICATIONS (list chronologically, most recent first)

1. _____
2. _____
3. _____
4. _____

RE: null

10. HEALTH STATUS AND ABILITY TO PERFORM (answer Y for yes or N for no)
(Note: Explain all Yes answers in comments Section.)
__a. Do you currently have any physical or mental impairments that could limit your clinical abilities?
__b. Are you currently taking any medications?
__c. Do you have any potentially-communicable disease?
__d. Have you been hospitalized for any reason in the past 5 years?
__e. Have you ever been psychiatrically hospitalized or diagnosed with a major psychiatric disorder?
__f. Are you currently under or have you ever received treatment for an alcohol or drug related condition?
__g. Have you ever been involved in the illegal use of controlled substances?

Comments: _____

_____
(use back of page if more space is needed)

11. MALPRACTICE, LICENSURE, PRIVILEGING ACTION, AND LEGAL HISTORY (Answer Y for yes or N for no. Explain all Y (yes) answers in Comments Section.)

__a. Have you ever been the subject of a malpractice claim? (Indicate final disposition or current status of claim in comments.)
__b. Have you ever been charged or a defendant in a felony or misdemeanor case? (Indicate final disposition of case in comments.)
__c. Has there been previously successful or currently pending challenges, revocation, or restriction to any licensure, certification, or registration (State, district, or Drug Enforcement Agency) to practice in any jurisdiction, or the voluntary/involuntary relinquishment of such licensure, certification, or registration?

Comments: _____

_____

_____

_____

12. OFF DUTY EMPLOYMENT INFORMATION (specify other facilities where you currently hold clinical privileges.)
Institution/Department Full Address Privilege/Specialty

1. _____

2. _____

3. _____

13. OTHER INFORMATION (include any additional information that you wish to bring to the attention of the credentials office?)

_____

_____

_____

_____

I affirm and attest that the information I have provided is complete and correct.

Signature: _____ Date: _____